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Prescribing Narcotics to Habitual and Addicted Narcotic Users

Medical and Legal Guidelines in California and Some Other Western States

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Confusion exists among physicians over the legal requirements and appropriate prescribing of narcotics to addicted or habitual users of narcotics. The result has often been either (1) the deprivation of appropriate treatment for patients who desire detoxification or adequate pain relief, or (2) illegal prescribing by physicians. Because most narcotics are potent and dangerous substances, certain legal restrictions are necessary to protect the general public. State-approved programs have been established to prescribe methadone and propoxyphene napsylate for addiction treatment. Current laws and regulations in California permit every practicing physician to provide effective and safe treatment for addiction and pain relief.

FIFTEEN YEARS AGO, a Presidential Advisory Commission expressed concern that practicing physicians were confused over when narcotic drugs could be prescribed to drug addicts.[1] The Commission found that in most instances doctors shunned addicts as patients. The intervening years have seen little improvement in this situation. In California the confusion is exacerbated by a legal maze of statutory provisions that frequently seem to contradict each other. Medical and legal guidelines for prescribing narcotics to habitual and addicted narcotic users are summarized below. Some reported cases in which physicians have been disciplined for illegal prescribing are reviewed, and acceptable medical regimens are outlined to guide physicians in prescribing drugs to narcotic users for pain relief, detoxification or withdrawal, and medical maintenance.

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Restrictions on Prescribing Narcotics to Addicts and Habitual Users

If a patient is an addict or habitual user, or represents himself as such, the California Health and Safety Code permits a physician to prescribe, administer or dispense controlled substances only under the following conditions: (1) emergency treatment; (2) when the patient's addiction is complicated by the presence of incurable disease, serious accident or injury, or the infirmities of old age; or (3) in treatment of addiction which com-

plies with provisions of the California Uniform Controlled Substances Act, such as methadone programs approved by California's Research Advisory Panel.

The exceptions listed above form the basis of legal and medically appropriate prescribing for pain, detoxification and medical maintenance therapy. Table 1 summarizes prescribing restrictions for some of the common narcotics.

Emergency Pain Relief

The California Uniform Controlled Substances Act permits a physician to administer emergency treatment with controlled substances to an addict or habitual user of narcotics. A recently passed bill by the legislature (AB 2378) authorizes a physician to directly dispense a 72-hour supply of narcotics for pain purposes only whenever the patient is not expected to require additional amounts beyond this time period. Thus, the doctor who administers narcotics or other controlled substances to an accident victim has nothing to fear if it later turns out the victim is an addict. The exception even allows temporary administration of controlled substances to an addict in the stages of acute withdrawal, although it should be a one-time, one-dose treatment while the addict awaits more definitive care. In the case of *People vs Anderson* (29 Cal App 3d 551, 1972) a physician was charged with six counts of improperly issuing prescriptions to narcotic addicts. His defense was that he gave each of the six addicts a prescription for 10 mg of methadone (Dolophine) to be taken four times a day for four days, simply as emergency treatment until they could be admitted to a drug treatment program. Each of the prescriptions stated, "Take as directed and immediately cut down and immediately report to a Drug Abuse Center as arranged." Nonetheless, a conviction was upheld on the basis of expert testimony presented by the prosecution that no true medical emergency was present because none of the six patients was suffering from any acute withdrawal symptoms at the time he was in the defendant's office. Even the prosecution expert agreed, however, that

> it was proper for a doctor to give an addict a prescription for one or two doses of methadone if the addict was on his way to the hospital. The prescription, however, should last just long enough for the addict to get to the hospital, instead of the four days involved in each of the six orders here involved.

If any drugs listed on Schedule II of the California Uniform Controlled Substances Act are prescribed to a habitual user of narcotics, however, even for emergency pain relief, the California Health and Safety Code requires that a report be filed with the attorney general containing the name and address of the patient, the character of the injury or ailment, and the quantity and kind of controlled substance used (Table 1). In California, the attorney general's office provides a convenient registration card for physicians which can be obtained by contacting his office. Three points should be noted with respect to this requirement. First, the term "habitual user," as used in the law requiring a report, has been held unconstitutionally vague, except as applied to addicts, in the decision of *McCurty vs Board of Medical Examiners* (180 Cal App 2d 760, 1960). Thus, even though prescriptions to habitual users may be subject to the same limitations as addicts, the reporting requirement applies only to addicts. Some physicians, however, choose to register all habitual users of Schedule II substances, including hyperactive children for whom methylphenidate (Ritalin) is prescribed. Unnecessary or over-registration is, therefore, apparently preferred to under-registration to avoid any possible penalty. Second, the reporting requirement only includes drugs that are prescribed or furnished. Therefore, if an addict desires a Schedule II narcotic for pain relief while attending an emergency room, clinic or physician's office, and the physician issues a prescription for a Schedule II controlled substance, he must register the addict with the attorney general's office. If emergency Schedule II narcotics are administered, however, in a physician's office or hospital emergency room, a report need not be filed. Third, the Schedule II referred to is in the California Controlled Substances Schedule, and not the federal schedule. There are some significant differences. For example, barbiturates and methaqualone remain on Schedule III in California, while federal authorities have moved them to Schedule II. Thus, such prescriptions for these drugs would not have to be reported.

Nonemergency Pain Relief

Chronic pain may be treated with any narcotic chosen by the physician because the California Health and Safety Code permits a physician to prescribe "where the patient's addiction is complicated by the presence of incurable disease, serious accident or injury, or the infirmities of old

age." This situation includes terminal cancer, a neuromuscular disorder, arthritis, angina pectoris or other disease that may produce chronic, severe pain and require administration of narcotics even to the point of addiction. Physicians' confusion over this issue often deprives patients of humane treatment in relieving pain.[2,3] In addition, physicians may frequently withhold proper relief from addicts, because they erroneously assume an addict's regular narcotic dose will relieve the pain of accident, injury or disease. This is not the case, however, because addiction essentially eliminates the pain-relieving ability of an addict's regular maintenance dose. For this reason, addicts generally should be prescribed narcotics and other analgesic drugs in regular dosage for an accident, injury, illness or surgical procedure.[4] Several examples of the application of the legal right of physicians to prescribe the chronic use of narcotics for pain relief to narcotic addicts can be found in the decision of *Moran vs Board of Medical Examiners* (32 Cal 2d 301, 1948). Dr. Moran was charged with prescribing narcotics for three addicts. In each case, the court found the prescriptions were justified by the presence of an incurable disease. The first case involved a female addict complaining of severe pain in the left side of her face resulting from trifacial neuralgia. He injected her face with novacaine and alcohol, and on 18 different dates within two months, prescribed morphine sulphate for the pain. He discontinued treatment when the woman refused to enter a hospital after he had arranged for treatment of her addiction. The second case involved a male addict who was choking from an acute asthmatic attack. The doctor tried epinephrine, and when that did not work, administered vitamin C and morphine, which controlled the choking. He then prescribed morphine sulphate on nine occasions within a month. The third case was a

TABLE 1.—*California Restrictions on Some Common Narcotics When Prescribed for Addicts and Habitual Users*

	May Administer for Emergency Pain Relief Without Registration	*May Prescribe or Furnish for Pain Relief and Must Register Addict or Habitue*	*May Prescribe for Pain Relief and No Registration Required*	*May Prescribe for Detoxification in State-County Hospital, Jail, or Approved Facility if Addict or Habitue Registered*	*Formal Mechanism Established for State Approval to Use for Detoxification and Maintenance Treatments*
Schedule II					
Codeine	Yes	Yes	N/A	Yes	No
Morphine	Yes	Yes	N/A	Yes	No
Meperidine (Demerol)	Yes	Yes	N/A	Yes	No
Hydromorphone (Dilaudid)	Yes	Yes	N/A	Yes	No
Oxycodone (Percodan)	Yes	Yes	N/A	Yes	No
Opium extracts (Pantopon)	Yes	Yes	N/A	Yes	No
Hydrocodone	Yes	Yes	N/A	Yes	No
Methadone (Dolophine)	Yes	Yes	N/A	Yes	Yes
Schedule III					
Codeine mixtures (Empirin, Ascodeen)	Yes	N/A	Yes	No	No
Hydrocodone cough mixtures (Hycodan, Citra Forte, Tussend)	N/A	N/A	N/A	No	No
Scheduled IV					
N/A					
Schedule V					
Codeine mixtures (Actifed-C, Robitussin A-C)	N/A	N/A	N/A	No	No
Unscheduled					
Propoxyphene hydrochloride (Darvon)	Yes	N/A	Yes	No	No
Propoxyphene napsylate (Darvon-N)	Yes	N/A	Yes	No	Yes
Pentazocine (Talwin)	Yes	N/A	Yes	No	No

N/A = not applicable

patient afflicted with spinal arthritis, for whom Dr. Moran prescribed opium extracts (Pantopon) on two occasions for pain.

It is highly recommended that a physician initially attempt treatments other than use of narcotics before a diagnosis of incurable disease is made. This should be carefully documented in the patient's chart, because the physician must bear the burden of proving a claim of incurable disease for which narcotics are the only treatment. In the case of *People vs Lawrence* (198 Cal App 2d 54, 1961), a court held that the doctor had failed to prove that narcotics were necessary in a case where he prescribed 20 grains of morphine daily for four years to a 50-year-old woman with chronic uremia following the removal of a kidney. A prosecution expert testified that this was two to three times the dosage necessary for even the most excruciating pain. Thus, the mere presence of an underlying disease or disorder is not enough, if the prescribing exceeds what is reasonably necessary for treatment of that condition.

The same reporting requirements outlined for emergency pain relief are applicable to relief of pain in nonemergencies. If a Schedule II substance is prescribed to an addict, a report must be filed with the California attorney general's office.

Detoxification Treatment of Narcotic Addicts

Detoxification is the primary medical treatment for narcotic addicts. The type of detoxification legally permitted depends primarily on whether it takes place in an institution, state-approved methadone or propoxyphene napsylate program, or outpatient setting. Section 11217.5 of the California Health and Safety Code permits a licensed physician or surgeon to treat and detoxify an addict for addiction in any office or medical facility which, in his or her professional judgment, is medically proper for the rehabilitation and treatment of the addict. Treatment can include administering "those medications and therapeutic agents which, in the judgment of such physician and surgeon, are medically necessary, provided nothing in this section shall authorize the administration of any narcotic drug." It is important to note that this provision authorizes only the administration of nonnarcotic medications. "Administer" is defined to mean the direct application of a controlled substance, whether by injection, inhalation, ingestion or any other means, to the body of a patient for his immediate needs, either by the practitioner himself, or in the presence of the practitioner by his authorized agent or the patient (*People vs Anderson,* 29 Cal App 3d 551, 1972). An addict or habitual user given nonnarcotic drugs by a private physician does not have to be registered with the attorney general or reported to any law enforcement agency.

The major problem for physicians is to provide an office-based detoxification regimen that is legal and effective. A detoxification regimen for outpatient use that does not contain any drugs in the California Uniform Controlled Substances Act is given in Table 2. This method is described as symptomatic detoxification because medications are prescribed for each symptom (such as pain, myalgia, nausea or insomnia) as opposed to treatment of addiction.[5] It can be used by any California physician in any medical setting. Clonidine, a noncontrolled substance used for treating hypertension, recently has been reported to be effective in narcotic withdrawal, but early observations by one of the authors (F.S.T.) indicate that it is unpredictable in suppressing heroin abstinence symptoms.[6]

When methadone or propoxyphene napsylate (Darvon-N), in higher than symptomatic pain-relieving doses, is used for heroin detoxification or long-term maintenance, special legal approval is required. Section 11217 of the California Health and Safety Code, and Section 4351 of the Welfare and Institutions Code stipulate that the California Department of Health Services' approval

TABLE 2.—*A Symptomatic Narcotic Detoxification Regimen for Use by Physicians**

Drug	*Symptoms*	*Dosage*
Carisoprodol 300 mg (Soma)	Tenseness, anxiety, muscle spasm, insomnia	Give 4 times per day
Pentazocine 50 to 100 mg (Talwin)	Pain	Every 4 to 6 hours
Prochlorperazine 10 mg (Compazine)	Nausea	Give 4 times per day

*The above regimen is for the first day of detoxification, and dosages on subsequent days should be lowered sequentially so that all medications are stopped within 10 to 14 days. These regimens can be be used in any medical setting because they do not involve any California-controlled substance and treat a symptom rather than addiction. Use of this regimen does not require registration of a patient.

TABLE 3.—*Dosages of Schedule II Narcotics Allowed in Narcotic Detoxification Treatment*

*Drugs**	*0-15 Days*	*16-30 Days*
Opium	520 mg	260 mg
Morphine	260 mg	130 mg
Opium alkaloids (Pantopon)	390 mg	195 mg
Hydromorphone (Dilaudid)	65 mg	32 mg
Meperidine (Demerol)	400 mg	200 mg

*These drugs can be used only in state or county hospital, jail, prison, or state-approved facilities, and patients must be registered with the California attorney general. No more than one of the above drugs may be furnished, and all drugs must be discontinued at the end of 30 days from the first treatment.

is necessary for outpatient methadone treatment. Section 11480 of the California Health and Safety Code has established a Research Advisory Panel for controlled substances research. While the approved pain-relieving dose is 400 to 600 mg per day, the dosage required for treatment of addiction without use of ancillary medications is about 1,000 to 1,400 mg per day.[7] Regulations for methadone and propoxyphene napsylate approval have been published.[8-10] Propoxyphene napsylate (Darvon-N) has recently been classified as a federal Schedule IV narcotic. Use of this drug for narcotic treatment requires research approval from the United States Food and Drug Administration (FDA), Drug Enforcement Agency and California Research Advisory Panel.[9,10]

In the treatment of drug addiction involving the use of narcotic drugs other than methadone, the California Health and Safety Code (Section 11217) imposes numerous significant limitations. Treatment can only take place in a state or county hospital, a jail or prison, or a facility approved by the California Department of Health Services. Only a physician or a registered nurse can administer the drugs. Dosages are strictly in acordance with the schedule presented in Table 3.

Medical Maintenance Therapy for Narcotic Addicts

Methadone regulations found in the California Administrative Code and in the *Federal Register* define medical maintenance therapy for a narcotic addict as the administration of medication for longer than 21 days.[8,9] The use of methadone or propoxpyhene napsylate (Darvon-N) for narcotic maintenance treatment requires approvals as described above. Noncontrolled substances for maintenance treatment of psychiatric problems frequently associated with addiction may be prescribed to narcotic addicts and habitual users by any physician in any medical setting. This form of maintenance includes such therapies as tricyclic antidepressant agents for depression, benzodiazepine drugs for anxiety and phenothiazine drugs for thought disorder or psychosis.

Definition and Diagnosis of Narcotic Addicts and Habitual Users

The challenge that confronts physicians is to realize that all controlled substances are not narcotics and to determine whether a patient is an addict or habitual user of narcotic drugs, because the Uniform Controlled Substances Act of the California Health and Safety Code, Section 11156, provides that

> no person shall prescribe for or administer, or dispense a controlled substance to an addict or habitual user, or to any person representing himself as such, except as permitted by this division.

Narcotics are pharmacologically best defined as compounds that provide pain relief, produce tolerance, result in withdrawal signs and symptoms after chronic use, and suppress morphine withdrawal if chronic morphine administration is suddenly discontinued.[11-13] Many barbiturates, amphetamines, stimulants and sedative-hypnotic agents are classified as controlled substances because of their potential for abuse, but do not legally or pharmacologically meet the definition of a narcotic. The legal definition of "narcotic" is given in Section 11019 of the California Health and Safety Code, and includes opium and opiates, any salt, compound derivative or preparation thereof, and any chemical equivalents. It also includes cocaine, which does not correspond to the pharmacological definition.[11-13] Pentazocine (Talwin) and propoxyphene (Darvon) are not yet scheduled under the California Uniform Controlled Substances Act, although they meet pharmacological definitions of narcotics.[14-17] In addition, both bind to the opiate receptor site as do all other narcotics classified under the Uniform Controlled Substances Act.[18] Propoxyphene and pentazocine are now listed on Schedule IV of the Federal Controlled Substances Act.[19] Chronic users of propoxyphene or pentazocine in California may not be legally classified as narcotic addicts or habitual users, although medically they must be considered addicts or habitual users of narcotics.[14-17] Table 1 lists the common commer-

cially available narcotics and their respective schedule in the California Uniform Controlled Substances Act.

The California Health and Safety Code contains no definition of a narcotic addict or habitual user of narcotics. The California Welfare and Institutions Code, Section 3050, however, provides for compulsory civil commitment of addicts, and in that context, the courts have had occasion to carefully define the term "addict." In the case of *People vs Victor* (62 Cal 2d 280, 301-305, 1965), the requisites of addiction were said to be (1) emotional dependence on the drug in the sense that the user experiences a compulsive need to continue its use; (2) a tolerance to its effects which leads the user to require larger and more potent doses, and (3) physical dependence so that the user suffers withdrawal symptoms if he is deprived of his dosage (see also *People vs O'Neil* [62 Cal 2d 748, 752-756, 1965]). In the case of *Elder vs Board of Medical Examiners* (241 Cal App 2d 247, 1966), this definition was used to conclude that a physician who regularly prescribed the controlled substance methamphetamine, to be taken once, twice or three times a day as a treatment for "ex-addicts," was in violation of the law. The court further concluded that the treatment of postwithdrawal symptoms with a controlled substance remains treatment of addiction, and the addict remains an addict while his condition is sustained by a substitute controlled substance. In upholding the revocation of Dr. Elder's license to practice medicine, the court declined to judge the merits of his course of treatment, saying:

> It is not for this court to determine whether or not he was a Dr. Dooley or Dr. Schweitzer for the addicted denizens of the pavement jungle, or whether there are better methods of treating narcotic addicts than those which are provided by law. By his own admissions he had set up a course of treatment for those who admittedly have all the characteristics of addicts as defined in law and medicine.

The term "habitual user" is difficult to define, although some legal precedent has been established. Where the term is used alone, the courts have concluded the term is too vague, indefinite and uncertain, except as applied to addicts (*McCurty vs Board of Medical Examiners,* 180 Cal App 2d 760, 1960). Because the California Health and Safety Code, Section 11156, refers to both addicts and habitual users, however, its apparent broader legal coverage was intended. Thus, compulsive need to continue use alone appears to be sufficient to legally characterize a person as an "habitue" even though tolerance to and physical dependence on the narcotic do not exist.

TABLE 4.—*Minimal Criteria Recommended to Establish Absence of Narcotic Addiction or Habitual Use*

History
Patient denies any narcotic use in past month
Physical examination
Pupil size between 3 and 6 mm
No needle marks on extremities
No withdrawal signs of piloerection, rhinorrhea, lacrimation or diaphoresis
No signs of sedation, decreased reflexes or motor impairment

The general prohibition of Section 11156 of the California Health and Safety Code also extends to any person representing himself as an addict or habitual user, thus including the undercover investigator posing as an addict. In the case of *People vs Nunn* (46 Cal 2d 400, 1956), the court upheld the criminal conviction of a physician who wrote a prescription for 60 tablets of 1/16 grain hydromorphone (Dilaudid) to an undercover state narcotics inspector who told the doctor, "I am using H." The doctor replied, "I cannot write a prescription for heroin, but I can write for some legitimate drug like morphine or Dilaudid." The court found this was sufficient evidence to prove both that the inspector "represented himself to be an addict" and that the doctor knew he was an addict.

Whether it is necessary to prove actual knowledge on the part of the prescribing physician that the patient is an addict or habitual user remains an unsettled question. On the one hand, it seems unreasonable to hold a doctor strictly responsible when he has no reason to believe a patient is addicted. Many addicts make a career out of deceiving doctors and present very convincing complaints to obtain prescriptions for narcotics.[20] On the other hand, requiring actual knowledge would provide a convenient loop-hole for unethical physicians to avoid responsibility simply by not asking the right questions. A court is likely to adopt a middle ground, holding a physician liable if he or she should have known the patient was an addict. The most cursory history and physical examination, however, will usually provide a physican with reason to suspect a patient is addicted. Table 4 lists our minimal recommendations to determine the absence of addiction or habitual use of narcotics. Prescribing any con-

trolled substance without a good faith prior examination is itself a criminal offense, whether the patient is an addict or not, according to the California Business and Professions Code (*People vs Superior Court,* County of Orange, James Dewitt Douglas, Real Party in Interest, 85 Cal App 3d 734, 1978).

Laws in Other Western States

The medical regimens outlined here are equally available to physicians in Alaska, Arizona, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington and Wyoming. Unlike California, these states do not specifically limit prescribing to addicts, nor do they require such prescribing to be specially reported. The only limitation imposed on a physician by these states is that a prescription be issued in the course of "legitimate medical practice." While there are few court decisions in these states which explicate what "legitimate medical practice" is, at least those states which have adopted the Uniform Controlled Substances Act (Hawaii, Idaho, Montana, Nevada and Washington) will probably follow the interpretation given by the federal courts to similar language contained in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, on which the Uniform Controlled Substances Act was modelled. In that context, it has been held in the decision of *United States vs Rosen* (582 F, 2d 1032, 1978) that legitimate medical practice can include dispensing a moderate amount of drugs to a known addict in a good faith attempt to treat the addiction or to relieve conditions or suffering incidental to the condition. Cases finding a physician's prescribing to be outside the boundaries of "legitimate medical practice" have generally involved very blatant practices, such as issuing large numbers of prescriptions without physically examining the patient. In one recent case, the United States Supreme Court upheld the criminal conviction of a physician who wrote over 100 prescriptions a day for methadone for 54 days. In concluding that these prescriptions exceeded the bounds of professional practice, the Court noted in the decision of *United States vs Moore* (423 US 122, 1975) that

> he gave inadequate physical examinations or none at all. He ignored the results of the tests he did make. He did not give methadone at the clinic and took no precautions against its misuse and diversion. He did not regulate the dosage at all, prescribing as much and as frequently as the patient demanded. He did not charge for medical services rendered, but graduated his fee according to the number of tablets desired. In practical effect, he acted as a large-scale "pusher"—not as a physician.

For California physicians, prescribing is more regulated. Not only must a prescription meet the minimum threshold of "legitimate medical practice," it must also comply with specific statutory limitations which are unique to California law.

Comment

Various types of errors may occur because a physician does not understand rather complex narcotic laws and regulations. In some instances a physician may unknowingly violate narcotic regulations or withhold appropriate pain relief for fear of addicting a patient. As do all laws and regulations, the narcotic regulations contain some ambiguities, cumbersome restrictions, and perhaps even some irrational aspects. They do, however, allow for safe and effective treatment of pain, detoxification or medical maintenance of an addict, and case law shows examples to illustrate this.

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